Welcome to Our Office

PATIENT INFORMATION

Patient Name_____
(Last) (First) (Middle Initial)

Sex ☐ M ☐ F

Birth date_____ SS#_____

Address_____

City_____State_____Zip_____

Home (____)_____Cell(____)_____

Work(____)_____ext_____

E-mail_____

Best time and place to reach you_____

_____

Circle one: Married Single Other Minor

Patient Employer/School_____

Occupation_____

Employer Address_____

Spouse's Name_____

Spouse's Employer_____

Whom may we thank for referring you?_____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household.)

Name_____Relationship_____

Home (____)_____ Work ph (____)_____

FINANCIAL RESPONSIBILITY

Who is responsible for this account?_____

Do you have dental insurance? Yes No

Name of Insured _____

Insured's DOB:_____SS#_____

ID#_____

Relationship to patient_____

Insurance Co._____Group #_____

Address:_____

Employer_____

Is patient covered by additional insurance? Yes No

If yes, please complete the following

Name of Insured _____

Insured's DOB:_____SS#_____

ID#_____

Relationship to patient_____

Insurance Co._____Group #_____

Address:_____

Employer_____

DENTAL HISTORY

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Circle 'yes' or 'no' to indicate if you have had any of the following:

Bad breath . . . . . Yes No
Bleeding gums . . . . . Yes No
Blisters on lips or mouth . . . . Yes No
Burning sensation on tongue. Yes No
Chew on one side of mouth. . Yes No
Cigarette, pipe, cigar smoking Yes No
Clicking or popping jaw . . . . . Yes No
Dry mouth . . . . . Yes No
Fingernail biting . . . . . Yes No
Food collection between teeth . . . . . Yes No
Grinding teeth . . . . . Yes No
Gums swollen or tender . . . . . Yes No
Jaw pain or tiredness . . . . . Yes No
Lip or cheek biting . . . . . Yes No
Loose teeth or broken fillings Yes No
Mouth breathing. . . . . Yes No
Mouth pain, brushing . . . . . Yes No
Orthodontic treatment . . . . Yes No
Pain around ear . . . . . Yes No
Periodontal treatment . . . . Yes No
Sensitivity to cold . . . . . Yes No
Sensitivity to heat . . . . . Yes No
Sensitivity to sweets . . . . . Yes No
Sensitivity when biting . . . . . Yes No
Sores or growths in your mouth Yes No

If you could rate your smile from 1-10, what would it be?_____

Would you like to improve your smile?
_____ How?_____

MEDICAL INFORMATION

1. Are you having pain or discomfort at this time? ..... Yes No
2. Have you been a patient in the hospital during the past two years? ..... Yes No
3. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   Physician's name_____ Phone number _____
4. Have you taken any medication or drugs during the past two years? ..... Yes No
   Please list any medications you are currently taking and the correlating diagnosis: Pharmacy name _____

   _____ phone # _____

   _____
5. Are you sensitive or allergic to any medication or anesthetics? ..... Yes No
   If yes, please list: _____
6. Indicate which of the following you have had or have at present:

Heart Failure	Yes	No	Artificial Joints (hip, knee, etc.)....	Yes	No	Hepatitis A (infectious).....	Yes	No
Heart Disease or Attack...	Yes	No	Kidney Trouble	Yes	No	Hepatitis B (serum).....	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease.	Yes	No	Diabetes	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Thyroid Problems	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure.....	Yes	No	Glaucoma	Yes	No	Cold sores/Fever Blisters....	Yes	No
Arteriosclerosis	Yes	No	Cancer	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Anemia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Heart Surgery	Yes	No	Asthma	Yes	No	Bruises Easily	Yes	No
Rheumatic Fever.....	Yes	No	Hay Fever	Yes	No	Liver Disease .....,	Yes	No
Arthritis	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Rheumatism	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Cortisone Medicine	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Drug Addiction	Yes	No	Chemotherapy	Yes	No	Nervousness	Yes	No
Taken Bisphosphonates.....	Yes	No	Stroke	Yes	No	Tumors	Yes	No
Orally (Fosamax, Actonel, and Boniva are examples)						Developmentally Disabled	Yes	No
Or IV – as in chemotherapy (Zometa or Aredita are examples)						Weight loss, unexplained...	Yes	No

7. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because of tiredness? ..... Yes No
8. Do your ankles swell during the day? ..... Yes No
9. Do you ever wake up from sleep and feel short of breath? ..... Yes No
10. Are you on a special diet? ..... Yes No
11. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
    If yes, please list_____
12. Women: Taking birth control pills? Yes No Nursing? Yes No Are you pregnant? Yes No If yes, due date: _____

Consent:

1. I understand that the above information regarding my health is important for the doctor to provide dental care safely. I have answered the questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon and to use the appropriate medication and therapy indicated for such treatment. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that certain risks are present with any dental treatment including anesthetic agents (allergic reactions, redness, swelling, soreness, sloughing and other reactions can occur). Also, dental treatments are not always successful. On my request I can receive from this office a more complete list of possible risks.
4. I understand that during treatment, it may be necessary to change or add procedures due to conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any changes and additions as necessary. When making dentures a try-in visit will be done (except for immediate dentures). This is the time to make any changes. They can become loose, sore, and teeth or bases can break. A reline may be necessary. Dentures are made to fit individuals and therefore refunds cannot be given. Periodontal conditions (whether treated or untreated) can lead to tooth loss and occasionally other conditions throughout the body, such as heart disease and miscarriage.
5. I authorize my healthcare information including x-rays may be shared with insurance companies, pharmacists, and doctors who are involved in my treatment. Insurance payments will be assigned directly to my dentist.
6. I agree that the responsibility for payment for dental services provided in this office for myself or my dependants, whether or not insurance contributes, is mine, And due and payable at the time the services are rendered. Balances after 3 months old will be charged a 10% interest monthly and my account can be turned over to a collection agency with any charges incurred to be paid by patient.
7. I understand that it is my responsibility to advise this office of any changes in the information contained on this form.

Patient or Responsible Party_____ Signature_____ Date_____

Office use only: Reviewed by_____date_____